State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495416	A. BUILDING _____ B. WING _____	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY PONDS INC	21160 MAPLE BRANCH TERRACE ASHBURN, VA 20147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 05/10/16 through 05/12/16. The facility was not in substantial compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 44 certified bed facility was 41 at the time of the survey. The survey sample consisted of 11 current resident reviews (Residents #1 through # 10 and # 13) and two closed record reviews (Residents #11 and #12).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-250 A10 cross regerence F278 12VAC5-371-340 A cross refernece F371 12VAC5-371-250. Resident assessment and care planning cross reference to F280 12VAC5-371-300. Pharmaceutical services cross reference to F431	F 001		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy Grossman, WHA | TITLE: Administrator, Director of Continuing Care | (X6) DATE: 5/25/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/10/16 through 5/12/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 44 certified bed facility was 41 at the time of the survey. The survey sample consisted of 11 current resident reviews (Residents #1 through # 10 and # 13) and two closed record reviews (Residents #11 and #12).	F 000		
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272	RECEIVED MAY 26 2016 VDH/OLC F 272 – Plan of Correction 1) Section V Care Area Assessment for resident #1, #2, #3, #4 #5, #6, CAA will be updated to ensure the source of information is identified and that the CAA information is sufficient to contribute to the development and implementation of the resident's comprehensive care plan. 2) Current residents with comprehensive assessments completed since 3/1/16 will have their CAAs reviewed to ensure they contribute to the development of a comprehensive care plan. Modifications to the hard copy CAAs will be completed if it is necessary to contribute to the care plan's development/ implementation. 3) Manager or designee will educate the appropriate Interdisciplinary Team members on documenting the location and date of CAA documentation on the CAA Summary. 4) 10% of all comprehensive assessments completed each month will include a review of Section V, monthly for three months, by the MDS Coordinator to verify that the Care Areas Assessment (CAA) includes the location and date where information related to the CAA can be found. 5) Corrective Action Complete (6/26/16)	6/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Amy Grossman, LNHA Administrator, Director of Continuing Care 8/2/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the locations and dates for information used to complete the Care Area Assessment (CAA) was documented for six of 13 residents in the survey sample, Residents # 1, # 2, # 5, # 6, # 3 and # 4. 1. For Residents # 1, the facility staff failed to document the location and date of the information used to complete Section V on the CAA (Care Area Assessment) Summary Worksheet for the annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/11/16. 2. For Residents # 2, the facility staff failed to document the location and date of the information used to complete Section V on the CAA (Care Area Assessment) Summary Worksheet for the admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/9/15 and the significant change MDS	F 272		

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F 272	Continued From page 2 assessment with an ARD of 3/316. 3. For Residents # 5, the facility staff failed to document the location and date of the information used to complete Section V on the CAA (Care Area Assessment) Summary Worksheet for the significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/26/15. 4. For Residents # 6, the facility staff failed to document the location and date of the information used to complete Section V on the CAA (Care Area Assessment) Summary Worksheet for the admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/24/15. 5. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the admission MDS (minimum data set) assessment, with an ARD (assessment reference date) of 11/18/15 for Resident #3. 6. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the significant change in status MDS (minimum data set) assessment, with an ARD (assessment reference date) of 12/10/15 for Resident #4. The findings included: 1. Resident # 1 was admitted 4/19/14 with diagnoses that included but were not limited to: (1) Parkinson's disease (type of movement disorder), adult failure to thrive, (2) neuropathy (nerve damage), (3) urinary tract infection (an	F 272		

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F 272	Continued From page 3 infection in the urinary tract), (4) gastroesophageal reflux disease (stomach contents to leak back, or reflux, into the esophagus and irritate it) and depression. The most recent comprehensive MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 4/11/16 coded Resident # 1 as scoring a one on the brief interview for mental status (BIMS) of a score of 0 - 15, one- being severely impaired of cognition for making daily decisions. Resident # 1 was coded as being totally dependent of one staff member for all activities of daily living. Under Section V, CAA (Care Area Assessment) Summary of the annual assessment with an ARD of 4/11/16, the following were documented as being a triggered area (as evidenced by the number "one" in the box for column "A - Care Area Triggered: 05. ADL (activities of daily living) Function/Rehabilitation Potential, 06. Urinary Incontinence and Indwelling Catheter, 11. Falls, and 16. Pressure Ulcer." Under the column for "Location and Date of CAA documentation" it documented: · "05. ADL" failed to evidence any documentation of the location and date. · "06. Urinary Incontinence and Indwelling Catheter. See CAA # 6 NOTE 4/20/2016." · "11. Falls. See CAA # 11 NOTE 4/20/2016." · "16. Pressure Ulcer. See CAA # 16 NOTE 4/20/2016." Review of the CAA worksheet failed to reveal the date and location of the information that was obtained from the clinical record to complete this section.	F 272		

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F 272	Continued From page 4 On 5/11/16 at 12:55 p.m., in an interview with RN (registered nurse) # 1, MDS coordinator. After reviewing Section V and the CAA worksheets of Resident # 1's annual MDS assessment with the ARD of 4/11/16, RN # 1 stated that the location and date should document where the information came from to complete the care area assessment of the MDSs. RN # 1 further stated that prior to her beginning employment at the end of April 2016 the facility had an agency MDS coordinator who was in charge of the MDSs. RN # 1 also stated that they reference the RAI (resident assessment instrument) manual to complete the MDS. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. 2. Resident # 2 was readmitted to the facility on 11/3/15 with diagnoses that included but were not limited to: hip fracture, (3) urinary tract infection (an infection in the urinary tract), (5) dementia (a group of symptoms caused by disorders that affect the brain), muscle weakness, (4) gastroesophageal reflux disease (stomach contents to leak back, or reflux, into the esophagus and irritate it), (6) hypertension (high blood pressure), and (7) osteoporosis (makes your bones weak and more likely to break). The comprehensive MDS (Minimum Data Set) an admission assessment with an ARD of 11/9/15 coded Resident # 2 as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven- being severely impaired of cognition for making daily decisions. Resident #	F 272		

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F 272	Continued From page 5 2 was coded as requiring extensive assistance of one staff member for all activities of daily living. Under Section V, CAA (Care Area Assessment) Summary of the admission assessment with an ARD of 11/9/15, the following were documented as being a triggered area (as evidenced by the number "one" in the box for column "A - Care Area Triggered: 02. Cognitive Loss/Dementia, 05. ADL (activities of daily living) Function/Rehabilitation Potential, 06. Urinary Incontinence and Indwelling Catheter, 11. Falls, 14. Dehydration/Fluid maintenance, 16. Pressure Ulcer and 9. Pain " Under the column for "Location and Date of CAA documentation" it documented: · "02. Cognitive Loss/Dementia. See CAA # 2 NOTE 11/9/2015." · "05. ADL " See CAA # 5 NOTE 11/17/2015." · "06. Urinary Incontinence and Indwelling Catheter. See CAA # 6 NOTE 11/17/2015." · "11. Falls. See CAA # 11 NOTE 11/17/2015." · "14. Dehydration/Fluid maintenance. See CAA # 14 NOTE 11/17/2015." · "16. Pressure Ulcer. See CAA # 16 NOTE 11/17/2015." · "19. Pain. See CAA # 19 NOTE 11/17/2015." Review of the CAA worksheet failed to reveal the date and location of the information that was obtained from the clinical record to complete this section. The comprehensive MDS (Minimum Data Set) a significant change assessment with an ARD of 3/3/16 coded Resident # 2 as scoring a one on the brief interview for mental status (BIMS) of a score of 0 - 15, seven- being severely impaired of cognition for making daily decisions. Resident #	F 272		

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F 272	Continued From page 6 2 was coded as requiring extensive assistance of one staff member for all activities of daily living. Under Section V, CAA (Care Area Assessment) Summary of the admission assessment with an ARD of 3/3/16, the following were documented as being a triggered area (as evidenced by the number "one" in the box for column "A - Care Area Triggered: 06. Urinary Incontinence and Indwelling Catheter, 11. Falls and 16. Pressure Ulcer." Under the column for "Location and Date of CAA documentation" it documented: · "06. Urinary Incontinence and Indwelling Catheter. See CAA # 6 NOTE 3/17/2016." · "11. Falls. See CAA # 11 NOTE 3/17/2016." · "14. Dehydration/Fluid maintenance. See CAA # 14 NOTE 11/17/2015." · "16. Pressure Ulcer. See CAA # 16 NOTE 3/17/2016." Review of the CAA worksheet failed to reveal the date and location of the information that was obtained from the clinical record to complete this section. On 5/11/16 at 12:55 p.m., in an interview with RN (registered nurse) # 1, MDS coordinator. After reviewing Section V and the CAA worksheets of Resident # 2's admission MDS with the ARD of 11/9/15 and the significant change MDS with the ARD of 3/3/16, RN # 1 stated that the location and date should document where the information came from to complete the care area assessment of the MDSs. RN # 1 further stated that prior to her beginning employment at the end of April 2016 the facility had an agency MDS coordinator who was in charge of the MDSs. RN # 1 also stated that they reference the RAI (resident	F 272		

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F 272	Continued From page 7 assessment instrument) manual to complete the MDS. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. 3. Resident # 5 was admitted to the facility on 4/10/14 with diagnoses that included but were not limited to: (8) insomnia (common sleep disorder), (9) anxiety (fear), (5) dementia (a group of symptoms caused by disorders that affect the brain), (7) osteoporosis (makes your bones weak and more likely to break) and (10) chronic obstructive pulmonary disease (disease that makes it difficult to breathe that can lead to shortness of breath). The comprehensive MDS (Minimum Data Set) a significant change assessment with an ARD of 10/26/15 coded Resident # 5 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three- being severely impaired of cognition for making daily decisions. Resident # 5 was coded as requiring extensive assistance of one staff member for all activities of daily living. Under Section V, CAA (Care Area Assessment) Summary of the significant change assessment with an ARD of 10/26/15, the following were documented as being a triggered area (as evidenced by the number "one" in the box for column "A - Care Area Triggered: 02. Cognitive Loss/Dementia, 03. Visual Function, 05. ADL (activities of daily living) Function/Rehabilitation Potential, 06. Urinary Incontinence and Indwelling Catheter, 11. Falls, 12. Nutritional	F 272		

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F 272	Continued From page 8 Status and 16. Pressure Ulcer." Under the column for "Location and Date of CAA documentation" it documented: · "02. Cognitive Loss/Dementia. See CAA # 2 NOTE 10/29/2015." · "03. Visual Function. See CAA # 3 NOTE 11/4/2015." · "05. ADL " See CAA # 5 NOTE 11/4/2015." · "06. Urinary Incontinence and Indwelling Catheter. See CAA # 6 NOTE 11/4/2015." · "11. Falls. See CAA # 11 NOTE 11/4/2015." · "12. Nutritional Status. See CAA # 12 NOTE 11/4/2015." · "16. Pressure Ulcer. See CAA # 16 NOTE 11/4/2015." Review of the CAA worksheet failed to reveal the date and location of the information that was obtained from the clinical record to complete this section. On 5/11/16 at 12:55 p.m., in an interview with RN (registered nurse) # 1, MDS coordinator. After reviewing Section V and the CAA worksheets of Resident # 5's significant change MDS with the ARD of 10/26/15 RN # 1 stated that the location and date should document where the information came from to complete the care area assessment of the MDSs. RN # 1 further stated that prior to her beginning employment at the end of April 2016 the facility had an agency MDS coordinator who was in charge of the MDSs. RN # 1 also stated that they reference the RAI (resident assessment instrument) manual to complete the MDS. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings.	F 272		

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F 272	Continued From page 9 No further information was provided prior to exit. 4. Resident # 6 was admitted to the facility on 9/17/15 with diagnoses that included but were not limited to: arthritis, (6) hypertension (high blood pressure), retention of urine, (11) coronary artery disease (common type of heart disease) and (12) syncope and collapse (fainting). The comprehensive MDS (Minimum Data Set) an admission assessment with an ARD of 9/24/15 coded Resident # 6 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four- being severely impaired of cognition for making daily decisions. Resident # 6 was coded as requiring extensive assistance of one staff member for all activities of daily living. Under Section V, CAA (Care Area Assessment) Summary of the admission assessment with an ARD of 9/24/15, the following were documented as being a triggered area (as evidenced by the number "one" in the box for column "A - Care Area Triggered: 02. Cognitive Loss/Dementia, 03. Visual Function, 04. Communication, 05. ADL (activities of daily living) Function/Rehabilitation Potential, 06. Urinary Incontinence and Indwelling Catheter, 11. Falls, 16. Pressure Ulcer and 17. Psychotropic Drug Use." Under the column for "Location and Date of CAA documentation" it documented: · "02. Cognitive Loss/Dementia. See CAA # 2 NOTE 9/28/2015." · "03. Visual Function. See CAA # 3 NOTE 9/29/2015." · "04. Communication. See CAA # 4 NOTE	F 272		

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F 272	Continued From page 10 9/29/2015." · "05. ADL " See CAA # 5 NOTE 9/29/2015." · "06. Urinary Incontinence and Indwelling Catheter. See CAA # 6 NOTE 9/29/2015." · "11. Falls. See CAA # 11 NOTE 9/29/2015." · "16. Pressure Ulcer. See CAA # 16 NOTE 11/4/2015." · " 17. Psychotropic Drug Use. See CAA # 17 NOTE 9/29/2015." Review of the CAA worksheet failed to reveal the date and location of the information that was obtained from the clinical record to complete this section. On 5/11/16 at 12:55 p.m., in an interview with RN (registered nurse) # 1, MDS coordinator. After reviewing Section V and the CAA worksheets of Resident # 6's admission MDS with the ARD of 9/24/15, RN # 1 stated that the location and date should document where the information came from to complete the care area assessment of the MDSs. RN # 1 further stated that prior to her beginning employment at the end of April 2016 the facility had an agency MDS coordinator who was in charge of the MDSs. RN # 1 also stated that they reference the RAI (resident assessment instrument) manual to complete the MDS. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. Section V of the MDS documents at the top of the page the following instructions: 1. Check column A if the Care Area is triggered. 2. For each triggered Care Area, indicate whether	F 272		

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F 272	Continued From page 11 a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed in the Care Plan column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan. 3. Indicate in the Location and Date of CAA information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks and any referrals for this resident for this care area. CMS's (Centers for Medicare/Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual CH 4: CAA (Care Area Assessment) Process and Care Planning documented, "4.5 Other Considerations Regarding Use of the CAAs. CAA documentation. Use the "Location and Date of CAA Documentation " column on the CAA Summary (SectionV of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record." References: (1) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html>. (2) This information was obtained from the website: <https://www.google.com/#q=neuropathy+nih>. (3) This information was obtained from the	F 272		

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	495416	A. BUILDING _____ B. WING _____	05/12/2016

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F 272	Continued From page 12 website: <https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm>. (4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (5) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/dementia.html>. (6) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (7) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/osteoporosis.html>. (8) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/insomnia.html>. (9) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/anxiety.html#summary>. (10) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/copd.html>. (11) This information was obtained from the	F 272		

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F 272	Continued From page 13 website: <https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html>. (12) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/003092.htm>. 5. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the admission MDS (minimum data set) assessment, with an ARD (assessment reference date) of 11/18/15 for Resident #3. Resident #3 was admitted to the facility on 11/11/15. Resident #3's diagnoses included but were not limited to: urinary retention and Parkinson's disease (1). Resident #3's most recent MDS, a quarterly assessment with an ARD of 2/15/16, coded the resident's cognition as being severely impaired. A review of the clinical record revealed the most recent comprehensive MDS was an admission MDS with an ARD of 11/18/15. This review revealed in Section V (Care Area Assessment [CAA] Summary), a column, titled "Location and Date of CAA documentation." The data contained in this column for the following triggered areas did not contain location and date of the source of information. 02. Cognitive Loss/Dementia. The column titled, "Location and Date of CAA documentation" documented, "See CAA #2 NOTE 11/20/2015." 03. Visual Function. The column titled, "Location and Date of CAA documentation" documented,	F 272		

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F 272	Continued From page 14 "See CAA #3 NOTE 11/25/2015." 06. Urinary Incontinence and Indwelling Catheter. The column titled, "Location and Date of CAA documentation" documented, "See CAA #6 NOTE 11/25/2015." 11. Falls. The column titled, "Location and Date of CAA documentation" documented, "See CAA #11 NOTE 11/25/2015." 16. Pressure Ulcer. The column titled, "Location and Date of CAA documentation" documented, "See CAA #16 NOTE 11/25/2015." Review of the CAA notes for all of the above triggered areas failed to reveal documentation of location and date for the supporting documentation. On 5/11/16 at 12:57 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator [employed at the facility since April 2016]). RN #1 was asked the process for documenting location and date on the MDS assessment. RN #1 stated the MDS should contain documentation of where the information was found and the date the information was obtained. RN #1 stated she knew the MDS coordinators were not documenting location and date on the MDS assessments before she started working at the facility. RN #1 stated she references the CMS (Centers for Medicare & Medicaid Services) RAI (resident assessment instrument) manual when completing MDS assessments. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. No further information was presented prior to exit.	F 272		

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F 272	Continued From page 15 (1) Parkinson's disease is a nervous system disorder. This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024544/ 6. The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the significant change in status MDS (minimum data set) assessment, with an ARD (assessment reference date) of 12/10/15 for Resident #4. Resident #4 was admitted to the facility on 9/24/15. Resident #4's diagnoses included but were not limited to: acute kidney failure and depression. Resident #4's most recent MDS, a quarterly assessment with an ARD of 3/10/16, coded the resident's cognition as being moderately impaired. A review of the clinical record revealed the most recent comprehensive MDS was a significant change in status MDS with an ARD of 12/10/15. This review revealed in Section V (Care Area Assessment [CAA] Summary), a column, titled "Location and Date of CAA documentation." The data contained in this column for the following triggered areas did not contain location and date of the source of information. 01. Delirium. The column titled, "Location and Date of CAA documentation" was blank. 02. Cognitive Loss/Dementia. The column titled, "Location and Date of CAA documentation" documented, "See CAA #2 NOTE 12/10/2015." 03. Visual Function. The column titled, "Location and Date of CAA documentation" documented,	F 272		

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F 272	Continued From page 16 "See CAA #3 NOTE 12/28/2015." 04. Communication. The column titled, "Location and Date of CAA documentation" documented, "See CAA #4 NOTE 12/28/2015." 05. ADL (activities of daily living) Functional/Rehabilitation. The column titled, "Location and Date of CAA documentation" documented, "See CAA #5 NOTE 12/28/2015." 06. Urinary Incontinence and Indwelling Catheter. The column titled, "Location and Date of CAA documentation" documented, "See CAA #6 NOTE 12/28/2015." 08. Mood State. The column titled, "Location and Date of CAA documentation" was blank. 11. Falls. The column titled, "Location and Date of CAA documentation" documented, "See CAA #11 NOTE 12/28/2015." 16. Pressure Ulcer. The column titled, "Location and Date of CAA documentation" documented, "See CAA #16 NOTE 12/28/2015." 17. Psychotropic Drug Use. The column titled, "Location and Date of CAA documentation" documented, "See CAA #17 NOTE 12/28/2015." Review of the CAA notes for all of the above triggered areas failed to reveal documentation of location and date for the supporting documentation. On 5/11/16 at 12:57 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator [employed at the facility since April 2016]). RN #1 was asked the process for documenting location and date on the MDS assessment. RN #1 stated the MDS should contain documentation of where the information was found and the date the information was obtained. RN #1 stated she knew the MDS coordinators were not documenting location and	F 272		

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F 272	Continued From page 17 date on the MDS assessments before she started working at the facility. RN #1 stated she references the CMS (Centers for Medicare & Medicaid Services) RAI (resident assessment instrument) manual when completing MDS assessments. On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. No further information was presented prior to exit.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	F 278 – Plan of Correction 1) MDS for resident #2 will be corrected and re-submitted. 2) 100 % of MDSs with ARDs since 4/12/16 will be audited to ensure Activity and Pain Interviews are completed appropriately and corrected if necessary. 3) Manager or designee to educate staff on the pain and activity interview process for the MDS. 4) 10% audit of all MDS Activity and Pain Interviews to be conducted monthly for three months. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI. 5) Corrective Action to be complete: 6/26/16	6/26/16

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F 278	Continued From page 18 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility failed to complete an accurate MDS (minimum data set) assessment for one of 13 residents in the survey sample, Resident # 2. The facility staff failed to complete the activity and pain interviews before the ARD (assessment reference date) on Resident # 2's significant change MDS (Minimum Data Set) assessment with the ARD of 3/3/16. The findings include: The facility staff failed to complete the cognition, mood and pain interviews before the ARD (assessment reference date) on Resident # 8's quarterly MDS (Minimum Data Set) assessment with the ARD of 12/21/15. Resident # 2 was readmitted to the facility on 11/3/15 with diagnoses that included but were not limited to: hip fracture, (1) urinary tract infection (an infection in the urinary tract), (2) dementia (a group of symptoms caused by disorders that affect the brain), muscle weakness, (3) gastroesophageal reflux disease (stomach contents to leak back, or reflux, into the esophagus and irritate it), (4) hypertension (high blood pressure), and (5) osteoporosis (makes your bones weak and more likely to break).	F 278		

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F 278	Continued From page 19 Resident # 2's comprehensive MDS (Minimum Data Set) a significant change assessment with an ARD of 3/3/16 coded Resident # 2 as scoring a one on the brief interview for mental status (BIMS) of a score of 0 - 15, seven- being severely impaired of cognition for making daily decisions. Resident # 2 was coded as requiring extensive assistance of one staff member for all activities of daily living. Section B0700 "Makes Self Understood" coded Resident # 2 as "Understood" and section B0800 "Able To Understand Others" coded Resident # 2 as "Understands." Section F "Preferences of Customary Routine and Activities" of the significant change MDS assessment with an ARD of 3/3/16 documented, "Should Interview for Daily Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other. A dash (-) was coded in the box under section F0300. Review of sections F0400 "Interview for Daily Preferences", F0500 "Interview for Daily Activity Preferences" and F0600 "Daily and Activity Preferences Primary Respondent" revealed dashes in all areas indicating that the interview was not attempted. Section J "Health Conditions" of the significant change MDS assessment with an ARD of 3/3/16, documented, "J0200 Should Pain Assessment Interview be conducted? - Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, shortness of Breath (dyspnea)" was coded "0" (zero) for "Yes - Continue to J0300, Pain Presence." Review of Sections J0300 "Pain Presence,"J0400 "Pain	F 278		

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F 278	Continued From page 20 Frequency," J0500 "Pain Effect on Function," and J0600 "Pain Intensity" revealed the interview was not completed and the boxes were left blank. The staff assessment of the resident's pain was completed. On 5/11/16 at 12:55 p.m., an interview was conducted with RN (registered nurse) # 1, MDS coordinator. After reviewing sections Section F "Preferences of Customary Routine and Activities" and Section J "Health Conditions" of Resident # 2's significant change MDS with the ARD of 3/3/16 RN # 1 stated, "The interviews should have been attempted." RN # 1 also stated that they reference the RAI (resident assessment instrument) manual to complete the MDS. 3.0 Manual CH 4: CAA (Care Area Assessment) Process and Care Planning documented, "SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES Intent: The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences, and is not meant to be all-inclusive. SECTION J: HEALTH CONDITIONS Intent: The intent of the items in this section is to document a number of health conditions that	F 278		

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F 278	Continued From page 21 impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, and falls." On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit. References: (1) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm>. (2) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/dementia.html>. (3) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/osteoporos	F 278		

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F 278	Continued From page 22 is.html>.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to revise the comprehensive care plan for one of 13 residents in the survey sample, Resident #8. The facility staff failed to revise Resident #8's comprehensive care plan to reflect the resident's current health condition regarding congestive heart failure.	F 280	F 280 – Plan of Correction 1) Care plans for the residents affected were updated by 5/20/16. 2) 100 % of all Acute Healthcare Concerns section of care plans for residents on neighborhood will be reviewed and revised to reflect current updates. 3) Manager or designee to educate staff on the care planning processes and to review and revise care plans as appropriate. 4) 10% audit of resident care plans monthly for three months. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI. 5) Corrective Action to be complete: 6/26/16	6/26/16

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F 280	Continued From page 23 The findings include: Resident #8 was admitted to the facility on 11/19/15. Resident #8's diagnoses included but were not limited to: end stage renal (kidney) disease and congestive heart failure. Resident #8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/26/15, coded the resident as being cognitively intact. Resident #8's comprehensive care plan dated 3/3/16 documented, "5. Acute Health Concerns. I have the following diagnosis/diagnoses: CHF (Congestive Heart Failure)...These are my CHF nursing protocols: Contact my Medical Provider if I have weight gain of 3 or more pounds from admission weight..." Resident #8's most recent weight documented from admission was dated 11/24/15 and was 137.2 pounds Review of Resident #8's weights revealed a weight gain of three or more pounds from admission weight on the following dates: 1/13/16- 141.8 pounds 2/11/16- 145 pounds 3/7/16- 144 pounds 4/5/16- 146.6 pounds 5/1/16- 146.6 pounds Review of nurses' notes and physicians' progress notes from January 2016 through May 2016 failed to reveal Resident #8's physician was notified regarding the above weight gains.	F 280		

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F 280	Continued From page 24 On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. On 5/12/16 at 8:12 a.m., an interview was conducted with RN (registered nurse) #2 (the manager). RN #2 stated Resident #8 had a history of congestive heart failure but this was no longer an acute problem. RN #2 stated Resident #8 had previously resided on the skilled nursing unit then resided on the assisted living unit then returned to the skilled nursing unit in November 2015. RN #2 stated when Resident #8 was re-admitted to the skilled nursing unit in November 2015, the computer system carried over the resident's previous acute problem of CHF and she RN #2 missed updating the care plan to reflect a history of CHF instead of an acute problem of CHF. RN #2 stated she corrected Resident #8's care plan the previous day and presented the revised care plan. The care plan was revised on 5/11/16 and documented a line drawn through "CHF (Congestive Heart Failure)" and the words, "H/O (history of) CHF" handwritten in. The revised care plan also documented a line drawn through, "Contact my Medical Provider if I have weight gain of 3 or more pounds from admission weight" and the words, "D/C (discontinue) 05-11-16" handwritten in. On 5/12/16 at 8:34 a.m., ASM #1 was made aware of the above findings. The facility policy titled, "Care/Service Plans" documented in part, "7. Care/Service plan will be updated by hand in-between completion of the holistic assessments/care/service plans..."	F 280		

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	495416	A. BUILDING _____ B. WING _____	05/12/2016

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F 280	Continued From page 25 No further information was presented prior to exit.	F 280		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store and prepare food in a sanitary manner. Observation of the kitchen was conducted on 5/10/16 at approximately 11:55 a.m. with OSM (other staff member) # 1, dietary manager. The following was observed: · Two quart container of honey dew melon on a shelf in the walk-in refrigerator with a UBD (use by date) of 5/9/16. · Approximately a half gallon of cocktail sauce in a gallon container on a shelf in the walk-in refrigerator with a UBD of 4/1/16 and an open date of 4/1/16. · A two quart bottle of stir fry sauce containing approximately one quart of sauce on a shelf in the walk-in refrigerator with a UBD of 5/1/16. · A two quart bottle of chili sauce containing	F 371	F 371 – Plan of Correction 1) Items identified were immediately discarded. Food processor was re-washed and stored appropriately. (5/10/16) 2) 100% of refrigerator items audited to identify any open items and ensure proper labeling and storage. (5/13/16) 3) Manager or designee to educate staff on the proper procedures for food storage. 4) Daily sanitary rounds to be completed initially for one month, weekly thereafter for three months. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI. 5) Corrective Action to be complete: 6/26/16	6/26/16

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F 371	Continued From page 26 approximately one quart of sauce on a shelf in the walk-in refrigerator with a UBD of 5/1/16 and an open date of 4/1/16. · A two quart pitcher of ice tea containing approximately one quart on a shelf in the reach-in refrigerator with a UBD of 5/7/16 and an open date of 5/7/16. · Observation of the food preparation table revealed a food processor. When asked if the food processor was cleaned and ready for use OSM # 1 stated, "Yes." Observation of the food processor revealed the inside of the lid; the blade and the inside of the bowl were covered with water. When asked about the inside components of the food processor being wet OSM # 1 stated, "It should not have been put away wet." On 5/11/16 at approximately 11:30 a.m. an interview was conducted with OSM # 1. When asked to describe the procedure that is followed to ensure expired food is not available OSM # 1 stated, "Stock is checked at least once a week by myself and it should be done daily by the cook." When asked about the food items found in the refrigerators past the use by dates OSM # 1 stated, "They should have been removed prior to the use by dates." The facility's policy "Pot, Pan and Utensil Cleaning" documented, "7. Remove from sanitizing sink and invert on drain board. Let air dry. Completely air dry before stacking." On 5/11/16 at 5:50 p.m., ASM (administrative staff member) #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 371		

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F 431	Continued From page 27	F 431		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	F 431 – Plan of Correction 1) PPD vial found during survey was discarded. Licensed nurses educated regarding dating of vials when opened. (5/27/16) 2) A 100% audit of other medication vials stored in the refrigerator completed to ensure that the vials are dated when opened. Any vials not dated will be discarded. (5/13/16) 3) Manager or designee to educate all licensed staff on practices related to medication vial dating. 4) Audit of all medication rooms will be completed to ensure items are properly dated when opened. Audit randomly conducted weekly for four weeks, then monthly each shift for three months. Corrective action will be initiated for any variances and findings will be reported to PIRMS/QA/QI. 5) Corrective Action to be complete: 6/26/16	6/26/16

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F 431	Continued From page 28 Based on observation, staff interview and facility document review, it was determined that the facility staff failed to label medication in a safe manner in one of one medication room. The facility staff failed to label an open date on one vial of Aplisol PPD (purified protein derivative) solution (a medication used in the diagnosis of tuberculosis [lung infection]) (1). Per manufacturer's instructions, the medication must be discarded 30 days after being opened. The findings include: On 5/10/16 at 12:35 p.m., observation of the medication room was conducted. One vial of PPD solution was observed open and approximately one fourth full in the medication room refrigerator. No open date was documented on the vial or the box that contained the vial. The manufacturer's box that contained the vial documented, "once entered, vial should be discarded after 30 days." At this time, an interview was conducted with LPN (licensed practical nurse) #1 regarding the labeling and storage of medications. LPN #1 stated, "usually we put a date on there and keep (the medication) refrigerated." LPN #1 confirmed no open date was documented on the vial or the box that contained the vial. LPN #1 stated she would discard the vial. The manufacturer's instructions documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." The facility pharmacy policy titled, "Storage and Expiration of Medications, Biologicals, Syringes	F 431		

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F 431	Continued From page 29 and Needles" documented in part, "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened..." On 5/11/16 at 12:50 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above finding. No further information was presented prior to exit. (1) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134	F 431		